County of Los Angeles
Department of Mental Health

Contract Providers Transition Project
(CPTP)

SUBMITTING SPECIAL
TYPES OF CLAIMS

Version 1.0

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DOCUMENT REVISION HISTORY

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1. Submitting Group Claims

Group claims need to be entered properly in order to be reimbursed for rendering group services including other/additional staff in the group claims.

1. Only one claim per DMH client should be submitted for a group session, regardless of the number of providers participating.

2. Total billable time is calculated by adding all the providers' times, including any documentation time. (Total of all providers' face-to-face time + Total of all providers' other time = Total billable time)

3. Each claim includes the total time / number of clients "represented", absent DMH clients may be represented by collaterals. Non-DMH clients are only counted if they are present.

4. The billing calculation should add the number of DMH clients present, the number of absent DMH clients represented by collateral and the number of non-DMH clients to get the total number of clients for the billing calculation. (Number of DMH clients present + number of absent DMH clients represented by collateral + number of non-DMH clients = Total number of clients for the billing calculation)

5. The total claim amount for each claim is calculated as: (Total billable time) / (Total number of clients as calculated in paragraph 4 above).

EXAMPLES:

1. A 100 minute group session with five DMH clients present and two providers. The rendering provider spends 25 minutes on progress notes. The total time for the claim is 225 minutes (two providers * 100 minutes + 25 minutes of other time) / five DMH Clients) = 45 minutes per claim.

   The system should create five claims. Each claim is for 45 minutes. Either provider can be included in the claim as the rendering provider.

2. A 100 minute group session with four DMH clients present and one absent DMH client represented by collateral and two providers. The rendering provider spends 25 minutes on progress notes. The total time for the claim is 225 minutes (two providers * 100 minutes + 25 minutes of other time) / five DMH Clients) = 45 minutes per claim.

   The system should create five claims. Each claim is for 45 minutes. Either provider can be included in the claim as the rendering provider.

3. A 100 minute group session with four DMH clients present and one collateral accompanying a DMH client who is present, and two providers. The rendering provider spends 25 minutes on progress notes. The total time for the claim is 225 minutes (two providers * 100 minutes + 25 minutes of other time) / four DMH Clients) = 56.25 minutes per claim. The claim fractional minutes are rounded up or down based on the following formula. If the fractional minutes equal .5 or above, round up to the nearest minute, otherwise, round down. In this case, the minutes per claim would become 56.

   The system should create four claims. Each claim is for 56 minutes. Either provider can be included in the claim as the rendering provider.

4. A 100 minute group session with four DMH clients present and one non-DMH client present; and two providers. The rendering provider spends 25 minutes on progress notes. The total time for the claim is 225 minutes (two providers * 100 minutes + 25 minutes of other time) / four DMH Clients + one non-DMH client) = 45 minutes per claim.

   The system should create four claims. Each claim is for 45 minutes for four DMH clients. There is no claim created for the non-DMH client, however, they are counted in the billing calculation. Either provider can be included in the claim as the rendering provider.

2. Submitting Corrected Claims – Void and Replacement

The process for submitting corrected claims can improve your revenue process by correcting common denied messages before submitting EDI claims

1. If the original claim status is “DENIED” due to DMH RULES or CICS violations, what is the proper way to send in the corrected claim?

   Send in as an Original (new) claim with a unique submitter ClaimID.

2. If the original claim status is “DENIED” due to “FIN ADJ” at the State level, what is the proper way to send in a corrected claim?

   There are several possible scenarios depending upon how you wish to correct the claim.

   Scenario A: If you are not changing the local plan but wish to send a corrected claim back to the State, send in a Replacement claim.

Scenario B: If you are changing the local plan and sending the corrected claim back to the State, you must send in a Void and a Replacement claim. (See Note 1.)

Scenario C: If you are not changing the local plan and are not planning to send a corrected claim to the State (e.g., the client is no longer Medi-Cal eligible), you may choose to do nothing. The County may pay the provider from the local plan indicated on the original claim.

However, it might be best practice to send a Void for the original claim and send in a Replacement claim. This may be less confusing in reconciling your claims since you will not have to deal with getting paid on a "denied" claim.

Please also see Note 2 below for further details.

3. If the original claim status is "PENDING" and we need to fix it for some reason, what type of claim(s) do we send?

   First send in a Void, then send in the corrected claim as Original (new).

4. If the original claim status is "FORWARDED" and we need to fix it for some reason, what type of claim(s) do we send?

   First send in a Void, then send in the corrected claim as Original (new).

5. If the original claim status is "APPROVED" and we need to fix it for some reason, what type of claim(s) do we send?

   First send in a Void, then send in the corrected claim as Original (new).

Note 1: EDI submitters must void the first claim if they want to send in a replacement claim with another local plan. If they do not void the first claim and send in a replacement claim with a different local plan, it would be considered as a duplicate and DMH would not be able to catch it. The same claim would be billed twice, hence would be paid twice from two different local plans and/or Medi-Cal (if Medi-Cal approves the replacement claim).

If a claim is approved by the State, then it would be paid out of the Medi-Cal allocation; DMH would apply the FMAP (Federal Medical Assistance Percentage) as applicable depending on the type of MC (EPSDT or not).

Note 2: When the IS automatically denies a claim due to a Medi-Cal denial, this sets a status of 'Denied' in the IS and at this time the provider can send in a replacement (claim frequency 7) claim. If the provider does not include Medi-Cal on the subsequent replacement claim – the claim will not go to Medi-Cal.

Here is the step by step detail of the process:

1. Provider sends Claim to IS with Medi-Cal as a payer
2. Claim passes IS Rules and MHMIS edits
3. IS sends claim to Medi-Cal
4. Medi-Cal returns denied 835 to IS
5. IS automatically denies claim since Medi-Cal denies
6. IS sends denied 835 to provider
7. Provider can respond as in scenarios 2A, 2B, or 2C noted above. Note that the IS will only send the claim to Medi-Cal, if Medi-Cal is included in the replacement claim.